TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Raymond R. Fulp, D.O.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-16-3386-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This injured worker was admitted for this procedure through the EMERGENCY ROOM."

Amount in Dispute: $3,650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The surgery of 10/9/15 was not a function of a medical emergency … Dr. Fulp's operative is silent on any compartment syndrome related to his surgical procedure of 10/9/15. There is no pre/post-operative diagnosis other than lateral tibial plateau fracture … Dr. Fulp's bill has one diagnosis, S82.142D: displaced/bicondylar fracture … No payment is due for the surgery absent preauthorization…

Texas Mutual claim … is a participant in the Texas Star Network … Because this is network healthcare Rule 133.307 does not apply."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 9, 2015	Left Knee Surgery	$3,650.00	$1,983.07

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 provides definitions for terms relevant to medical billing.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. 28 Texas Administrative Code §134.600 sets out the requirements for preauthorization of services.

5. Texas Insurance Code §1305 puts forth the requirements for claims subject to certified health care networks.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-197 – Precertification/authorization/notification absent.
   - 786 – Denied for lack of preauthorization or preauthorization denial in accordance with the network contract.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724 – No additional payment after a reconsideration of services.
   - CAC-18 – Exact duplicate claim/service.
   - 736 – Duplicate appeal. Network contract applied by Texas Star Network.

Issues

1. Is the dispute in question eligible for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor provide documentation to sufficient to support that the services in dispute were provided to an injured employee experiencing a medical emergency as defined by 28 Texas Administrative Code §133.2(5)?
3. Did the services in question require preauthorization?
4. What is the maximum allowable reimbursement (MAR) for the disputed services?

Findings

1. Ray R. Fulp, III, D.O. is seeking reimbursement for left knee surgery performed on October 9, 2015, pursuant to 28 Texas Administrative Code §133.307. Texas Mutual Insurance Company (Texas Mutual) argued in its position statement that, "Texas Mutual claim … is a participant in the Texas Star Network … Because this is network healthcare Rule 133.307 does not apply."

   The division's authority to resolve matters involving employees enrolled in a certified health care network is limited to the conditions outlined in the applicable portions of Texas Insurance Code, Chapter 1305, and limited application of Texas Labor Code statutes and rules, including 28 Texas Administrative Code §133.307.

   Review of available information finds that Dr. Fulp is not in the Texas Star Network. Texas Insurance Code §1305.153(c) provides that "out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation." Section 1305.006 outlines the insurance carrier's liability for out-of-network health care, stating:

   > An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:
   > (1) emergency care;
   > (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and
   > (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103.

   Therefore, the services in question must meet one of the exceptions found in Texas Insurance Code §1305.006 to be eligible for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307. The division will consider the evidence presented to determine if one of the exceptions was met.

2. Dr. Fulp argued that the services in question were provided to an injured employee experiencing a medical emergency as defined by 28 Texas Administrative Code §133.2. A medical emergency is defined in 28 Texas Administrative Code §133.2(5) as:

   > (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

(i) placing the patient's health or bodily functions in serious jeopardy, or
(ii) serious dysfunction of any body organ or part;

Specifically, documentation submitted to the division that the injured employee experienced a sudden onset of a medical condition that required immediate attention – the absence of which could have reasonably resulted in placing the patient's health or bodily functions in serious jeopardy.

Submitted documentation stated that "the patient presented to the emergency room … [with complaints] of left knee pain, swelling and decreased mobility … The patient had tenderness, swelling and limited range of motion of the left patellar knee area." The patient was then referred to Dr. Fulp for immediate surgery. Dr. Fulp, in turn observed that "patient's left leg was very painful to palpation and presented with warmth along with moderate effusion," and proceeded to perform an open reduction and internal fixation to left tibia x 2 cannulated screws … intraoperative radiographs … intralesional injections x 6 to 2 lateral incisions … [and] application of knee immobilizer" to repair a lateral tibial plateau fracture.

The division concludes that the services in question were provided to an injured employee experiencing a medical emergency as defined by 28 Texas Administrative Code §133.2. The services in question are, therefore, eligible for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307 and will be reviewed per applicable rules and fee guidelines.

3. Texas Mutual denied the services in question with claim adjustment reason codes CAC-197 – "PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT," and 786 – "DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT." 28 Texas Administrative Code §134.600(c) states:

> The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:
> (1) listed in subsection (p) or (q) of this section only when the following situations occur:
> (A) **an emergency** [emphasis added], as defined in Chapter 133 of this title (relating to General Medical Provisions);
> (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;
> (C) concurrent utilization review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or
> (D) when ordered by the commissioner

In addition, Texas Insurance Code §1305.006 states:

> An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:
> (1) **emergency care** [emphasis added];
> (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and
> (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103.

Because the services in question were performed as an emergency, the services did not require preauthorization.

4. Dr. Fulp is seeking reimbursement for the following procedure codes:

- 27535 – Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed.
- 11900-59 – Injection, intralesional; up to and including 7 lesions.
- 29505-59 – Application of long leg splint (thigh to ankle or toes).
- 73590-26 – Radiologic examination; tibia and fibula, 2 views: Professional component.

These services are professional medical services subject to the fee guidelines found in 28 Texas Administrative Code §134.203, which state, in relevant part:

(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83…
   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year…

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the division conversion factor. The Division conversion factor (DWC CF) for services performed in a facility setting for 2015 is $70.54.

The geographic practice cost index (GPCI) for work is multiplied by the relative value (RVU) for work. The practice expense (PE) GPCI is multiplied by the PE RVU. The malpractice (MP) GPCI is multiplied by the MP RVU. The sum of the calculations is multiplied by the Division conversion factor.

Procedure codes 27535, 11900, and 29505 have an indicator of "2" in field 21 of the Medicare Physician Fee Schedule (MPFS) found at https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx. Per Medicare policy, when field 21 of the MPFS has an indicator of "2," the following standard multiple procedure payment reduction (MPPR) rules apply:

- Procedures with this indicator, when performed on the same day are ranked by fee schedule amount.
- 100% of the fee schedule amount is assigned to the highest valued procedure.
- 50% of the fee schedule amount is assigned to the second through fifth highest procedures.
- Pay by the unit for services that are already reduced.

The total allowable amount for the disputed services is calculated as follows:

For procedure code 73590-26 on October 9, 2015, the relative value (RVU) for work of 0.17 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 0.17. The practice expense (PE) RVU of 0.07 multiplied by the PE GPCI of 0.920 is 0.0644. The malpractice (MP) RVU of 0.01 multiplied by the MP GPCI of 0.822 is 0.00822. The sum of 0.242620 is multiplied by the division conversion factor of $70.54 for a MAR of $17.11.

For procedure code 27535 on October 9, 2015, the relative value (RVU) for work of 13.41 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 13.41. The practice expense (PE) RVU of 9.77 multiplied by the PE GPCI of 0.920 is 8.9884. The malpractice (MP) RVU of 2.71 multiplied by the MP GPCI of 0.822 is 2.22762. The sum of 24.62602 is multiplied by the division conversion factor of $70.54 for a MAR of $1,737.12. This procedure is the highest valued procedure with an MPFS indicator of "2."

For procedure code 11900-59 on October 9, 2015, the relative value (RVU) for work of 0.52 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 0.52. The practice expense (PE) RVU of 0.31 multiplied by the PE GPCI of 0.920 is 0.2852. The malpractice (MP) RVU of 0.06 multiplied by the MP GPCI of 0.822 is 0.04932. The sum of 0.85452 is multiplied by the division conversion factor of $70.54 for a MAR of $60.28. This procedure is not the highest valued procedure with an MPFS indicator of "2." It is therefore reimbursed at 50% of the fee schedule amount. This amount is $30.14, which is multiplied by 6 units for a total allowable of $180.84.

For procedure code 29505-59 on October 9, 2015, the relative value (RVU) for work of 0.69 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 0.69. The practice expense (PE) RVU of 0.64 multiplied by the PE GPCI of 0.920 is 0.5888. The malpractice (MP) RVU of 0.10 multiplied by the MP GPCI of 0.822 is 0.0822. The sum of 1.361 is multiplied by the division conversion factor of $70.54 for a MAR of $96.00. This procedure is not the highest valued procedure with an MPFS indicator of "2." It is therefore reimbursed at 50% of the fee schedule amount. The total allowable amount for this procedure is $48.00.

The total allowable for the disputed services is $1,983.07. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,983.07.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,983.07, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	February 1, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.